PATIENT INFORMATION FORM

PATIENT INFORMATION

LAST NAME | FIRST NAME | MI

ADDRESS

CITY | STATE | ZIP

Garment Set(s) Required
Upper Extremity ☐ LEFT ☐ RIGHT
Lower Extremity ☐ LEFT ☐ RIGHT
Trunk ☐
Chest ☐
Head and Neck ☐

HOME PHONE | MOBILE PHONE | WORK PHONE

EMAIL | DATE OF BIRTH | GENDER ☐ Female ☐ Male

EMPLOYER | EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT US?
☐ Physician ☐ Therapist ☐ Internet ☐ Friend ☐ Advertisement ☐ Other:

INSURANCE INFORMATION

TYPE OF INSURANCE
PLEASE CHECK ☐ **Private Health Insurance** ☐ **Workers' Comp** ☐ **Medicare** ☐ **Medicaid** ☐ **Self-Pay**

DATE OF INJURY IF WORKERS' COMP | WORKERS' COMP CLAIM NUMBER

PRIMARY INSURANCE COMPANY | PHONE NUMBER

NAME OF POLICY HOLDER | PATIENT'S RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other

DATE OF BIRTH OF POLICY HOLDER | EMPLOYER

IDENTIFICATION NUMBER | GROUP NUMBER

SECONDARY INSURANCE COMPANY | PHONE NUMBER

NAME OF POLICY HOLDER | DATE OF BIRTH OF POLICY HOLDER | PATIENT'S RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other

IDENTIFICATION NUMBER | GROUP NUMBER

PRESCRIBER INFORMATION

PRESCRIBER'S NAME | NPI (NATIONAL PROVIDER NUMBER)

CLINIC NAME | PHONE | FAX

ADDRESS | CITY | STATE | ZIP

THERAPIST INFORMATION

THERAPIST'S NAME

WORK EMAIL APPROVED TO EMAIL DOCUMENTS ☐ Yes ☐ No

PHONE | FAX

FACILITY/CLINIC INFORMATION

FACILITY/CLINIC NAME

ADDRESS

CITY | STATE | ZIP

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Toll-Free Fax: 866.435.3949
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